

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM APPLICATION FOR SUPPLEMENTAL CARE

There is a new state law (Welfare and Institutions Code section 12301.07) that requires a 20-percent reduction in each IHSS recipient's authorized monthly service hours. Beginning January 1, 2012, your authorized monthly service hours will be reduced by 20-percent.

If you believe that the reduction in your authorized service hours puts you at serious risk of out-of-home placement, you can ask for IHSS Supplemental Care by completing this application and returning it to the county IHSS office. The county will review your application and determine whether you are at serious risk of out-of-home placement.

If you ask for IHSS Supplemental Care within 15 days of receiving notice of the reduction, or you mail **this application to the county and it is postmarked no later than January 3, 2012**, the reduction in your service hours will not go into effect until the county determines if you are at serious risk of out-of-home placement. If the county determines that you are at serious risk of out-of-home placement, your service hours may not be reduced at all or they may be reduced less than 20-percent.

If you do not ask for IHSS Supplemental Care within 15 days of receiving notice of the reduction, or mail this application to the county with a postmarked date of January 4, 2012 or after, the reduction in your service hours will go into effect but you can still request IHSS Supplemental Care until March 1, 2012. If the county determines that you are at serious risk of out-of-home placement, your service hours may be partially or fully restored.

To apply for IHSS Supplemental Care, complete this application and return it to the following address:

RECIPIENT INFORMATION

| | | | |
|-----------------------------|--|------------------------------------|--|
| Name: | | IHSS Case #: | |
| Street Address: | | | |
| City: | | ZIP Code: | |
| Phone Number: () - | | Date of Birth: | |
| IHSS Worker Name: | | IHSS Worker Phone #: () - | |
| Signature: | | Date: | |

If someone else is making this request on behalf of the recipient, provide the following information:

| | |
|-------|----------------------------|
| Name: | Relationship to Recipient: |
|-------|----------------------------|

Explain how the 20-percent reduction in your authorized service hours would put you at serious risk of out-of-home placement (if you need more space, attach another page):